Approved, SCAO

Original - Records custodian
1st copy - Court
2nd copy - Requesting party

STATE OF MICHIGAN JUDICIAL DISTRICT JUDICIAL CIRCUIT	AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION	CASE NO.

Court address **Court telephone no.**

Plaintiff	v	Defendant

AUTHORIZATION

1. _____ _____ _____
   Patient's name | Social security no. | Date of birth

2. I authorize _____
   Name and address of doctor, hospital, or other custodian of medical information

   _____

   _____

   to release _____
   Description of medical information to be released

   _____

   _____

   to _____
   Name and address of party to whom the information is to be given

3. I understand that unless I expressly direct otherwise:

   a) the custodian will make the medical information reasonably available for inspection and copying, or

   b) the custodian will deliver to the requesting party the original information or a true and exact copy of the original information accompanied by the certificate on the reverse side of this authorization.

   I understand that medical information may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS, and ARC.

4. This authorization is made in accordance with Michigan Court Rules and is valid for six months after being signed. This authorization is signed to make medical information regarding me available to the other party(ies) to the lawsuit listed above for their use in any stage of the lawsuit. The medical information covered by this release is relevant because my mental or physical condition is in controversy in the lawsuit.

5. I understand that I may revoke this authorization, except to the extent action has already been taken in reliance upon this authorization, at any time by sending a written revocation to the doctor, hospital, or other custodian of medical information.

_____
Date

_____
Signature

_____
Name (type or print)

_____
Address

_____
City, state, zip Telephone no.

MCL 333.5131(5)(d); MSA 14.15(5131(5)(d)),
MCR 2.506(I)(1)(b), MCR 2.314

CERTIFICATE

1. I am the custodian of medical information for _____ (Organization).
2. I received the attached authorization for release of medical information on _____ (Date).
3. I have examined the original medical information regarding this patient and have attached a true and complete copy of the the information that was described in the authorization.
4. This certificate is made in accordance with Michigan Court Rule.

I declare that the statements above are true to the best of my information, knowledge, and belief.

_____
Date

_____
Signature

_____
Name (type or print)

_____
Address

_____
City, state, zip Telephone no.